PATIENT INFORMATION

Medicaid ID:_____ Provider Name_____
Recipient Name:_____SSN:_____DOB:_____
Address:_____

I. Provider Section

Patient Status (Complete Appropriate Blocks) Report any admission, discharge, and/or change in patient status
Patient admitted to this facility/service on _____(date)

Level of care: ☐ Skilled ☐ Intermediate

Patient discharged or expired on _____(date)

Discharged to: ☐ Home ☐ Hospital ☐ Other Facility ☐ Expired

☐ Case in need of review/DMAS 122 requested

☐ Personal Funds Account balance $_____

☐ Patient's income or deductions have changed

☐ Explain/other:_____

Prepared by Name:_____ Title:_____

Telephone:_____ Date:_____

II. DSS Section

Eligibility Information: (Check One)

☐ Is eligible for full Medicaid services beginning _____(date)

☐ Is ineligible for Medicaid services

☐ Is eligible for QMB Medicaid only

Is ineligible for Medicaid payment of LTC services from_____to_____due to asset transfer.

☐ Is eligible for Medicare premium payment only

☐ Has Medicare Part A insurance

☐ Has other health insurance

III. Patient Pay Information

	MMYY	MMYY	MMYY
	_____	_____	_____
Patient Pay amount	_____	_____	_____
Comments:			

NOTE: Medicaid long-term care providers cannot collect more than the Medicaid rate from the patient. Income is used for the cost of care in the month in which it is received, e.g., the SSA check received in January is used toward the cost of care in January.

Worker Name:_____

Agency Name:_____FIPS Code:_____

Telephone:_____ **Date:**_____

PATIENT INFORMATION
FORM NUMBER: DMAS-122

PURPOSE OF FORM--To allow the local DSS and the nursing facility or Medicaid Community-based Care provider to exchange information regarding:

1. The Medicaid eligibility status of a patient;
2. The amount of income an eligible patient must pay to the provider toward the cost of care;
3. A change in the patient's level of care;
4. Admission or discharge of a patient to an institution or Medicaid CBC services, or death of a patient;
5. Other information known to the provider that might cause a change in the eligibility status or patient pay amounts.

USE OF FORM--Initiated by either the local DSS or the provider of care. The local DSS must complete the form for each nursing facility or CBC waiver patient at the time initial eligibility is determined or when a Medicaid enrolled recipient enters a nursing facility or CBC services. A new form must be prepared by the local DSS whenever there is any change in the patient's circumstances that results in a change in the amount of patient pay or the patient's eligibility status. The local DSS must send an updated form to the provider at least once a year, even if there is no change in patient pay.

The provider must use the form to show admission date, to request a Medicaid eligibility status, Medicaid recipient I.D., and patient pay amount; to notify the local DSS of changes in the patient's circumstances, discharge or death.

NUMBER OF COPIES--Original and one copy for nursing facility patients and original and two copies for CBC patients.

DISTRIBUTION OF COPIES--For nursing facility patients, send the original to the nursing facility and file the copy in the eligibility case folder. For Medicaid CBC patients, refer to section M1470.800 B.2. to determine where the original and any copies of forms are sent.

INSTRUCTIONS FOR PREPARATION OF THE FORM--Complete the heading with the name of the nursing home or Medicaid CBC provider, the address, the patient's name, social security number, and Medicaid recipient I.D.

Section I is for the provider to complete. Section II must be completed by the local DSS. Fill in the appropriate spaces.

Eligibility Information

1. Check the first block on an initial form sent in conjunction with the approval of a new Medicaid application, showing the effective date of coverage.
2. Check the second block if the individual is ineligible for payment of **all** Medicaid services.
3. Check the third block if the individual is eligible as QMB-only (not dually eligible).
4. Check the fourth block if ineligible for Medicaid payment due to transfer of assets. Dates of disqualification must be listed on the form. Send copy to DMAS.
5. Check the fifth block if eligible for Medicare premium payment only.
6. Check the sixth block if the individual has Medicare Part A insurance.
7. Check the last block if individual has other health insurance.

Patient Pay Information

Enter month and year in which the patient pay amount is effective. Enter the patient pay amount under the appropriate month and year.

Fill in the name of the EW, the local DSS agency name, FIPS code and telephone number and the date the form was completed.